CLINOVATE
Advances in Medicine and Healthcare
eISSN: 3107-4421

Volume 2, Issue 1, Jan-Apr 2026
DOI: 10.5281/zenodo.19666730

Case Report

Cognitive Behavioral Therapy for Major Depressive Disorder with Peripartum Onset: A Clinical Case Study

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Abstract

Background: Major Depressive Disorder with peripartum onset is a common psychiatric condition affecting women during the postpartum period and is associated with significant consequences for maternal functioning, infant development, and family well-being. Early identification and timely psychological intervention are essential to prevent chronic morbidity and adverse maternal–infant outcomes. Cognitive Behavioral Therapy (CBT) is a well-established evidence-based treatment for postpartum depression, offering an effective non-pharmacological therapeutic option.
Case Presentation: This is a case of a 28-year-old primiparous woman who presented six weeks postpartum with persistent low mood, tearfulness, excessive guilt related to perceived maternal inadequacy, sleep disturbance, and impaired bonding with her infant. Psychometric assessment revealed an Edinburgh Postnatal Depression Scale (EPDS) score of 18 and a Beck Depression Inventory-II (BDI-II) score within the moderate depressive range. There was no prior psychiatric history or significant medical illness.
Management & Outcome: The patient underwent a structured 12-session Cognitive Behavioral Therapy program focusing on psychoeducation, behavioral activation, cognitive restructuring, problem-solving strategies, and relapse prevention. Family psychoeducation was also incorporated to improve social support. Progressive clinical improvement was observed during therapy, with EPDS scores decreasing to 9 by session eight and to 5 at completion of treatment. Symptom remission and functional recovery were maintained at three-month follow-up.
Conclusion: This case highlights the effectiveness of structured CBT in the management of postpartum depression and underscores the importance of early screening and culturally informed psychological interventions in improving maternal mental health outcomes.

Keywords: Postpartum depression, Peripartum depression, Cognitive Behavioral Therapy, Maternal mental health

How to Cite: Saleem S & Javeed M. Cognitive Behavioral Therapy for Major Depressive Disorder with Peripartum Onset: A Clinical Case Study. CLINOVATE: Advances in Medicine and Healthcare 2026 Apr 24; 2(1). DOI: 10.5281/zenodo.19666730

Introduction

Mood disorders occurring during the peripartum period represent a significant contributor to maternal morbidity and can adversely affect maternal functioning, infant development, and overall family well-being.[1] Major Depressive Disorder with peripartum onset is commonly referred to as postpartum depression when symptoms emerge after childbirth, is one of the most prevalent psychiatric conditions affecting women during the reproductive period.[2] Global prevalence estimates suggest that approximately 10–20% of women experience clinically significant depressive symptoms during the postpartum period, with even higher rates reported in low- and middle-income countries due to socioeconomic stressors and limited access to mental health services.[3,4]
Unlike transient postpartum emotional disturbances such as the “baby blues,” which typically resolve within a few days, postpartum depression is characterized by persistent low mood, anhedonia, sleep disturbance, fatigue, impaired concentration, and feelings of excessive guilt or worthlessness.[5] These symptoms may interfere with maternal–infant bonding and caregiving capacity, potentially leading to long-term developmental consequences for the child if left untreated.
The etiology of peripartum depression is multifactorial, involving complex interactions between biological, psychological, and social factors. Hormonal fluctuations following childbirth, sleep deprivation, role transition, perceived maternal inadequacy, and limited social support are recognized contributors to vulnerability during this period.[6] Cultural expectations surrounding motherhood may further influence the presentation and help-seeking behavior of affected women, particularly within collectivistic family systems where emotional distress may be minimized or stigmatized.
Cognitive Behavioral Therapy (CBT) is widely recognized as an effective first-line treatment for mild to moderate postpartum depression and may also serve as an adjunct to pharmacotherapy in more severe cases.[7] CBT focuses on identifying and modifying maladaptive cognitive patterns, enhancing behavioral activation, and strengthening coping strategies that support emotional regulation

Received: 01/01/2026, Revised: 18/02/2026, Accepted: 09/03/2026, Published: 24/04/2026
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and adaptive functioning. Evidence suggests that structured CBT interventions can significantly reduce depressive symptoms and improve maternal adjustment during the postpartum period.[8]

Despite growing evidence supporting CBT in the management of postpartum depression, detailed clinical case reports illustrating structured therapeutic implementation remain relatively limited, particularly in South Asian clinical settings. The present case report describes the assessment, cognitive formulation, and therapeutic management of a 28-year-old primiparous woman diagnosed with Major Depressive Disorder with peripartum onset who was treated using a structured 12-session Cognitive Behavioral Therapy protocol.

Case Presentation

A 28-year-old married primiparous woman presented to the outpatient psychology clinic six weeks after delivering a healthy infant. She attended the consultation accompanied by her husband. The patient belonged to a middle socioeconomic background and resided in a joint family household.

During the first two weeks postpartum, the patient experienced persistent fatigue, sleep disturbance beyond that expected from infant-care demands, and frequent episodes of tearfulness. These symptoms were initially interpreted by family members as normal postpartum weakness and adjustment to childbirth.

By the third and fourth postpartum weeks, her symptoms progressed to persistent low mood, reduced appetite, diminished interest in daily activities, and pronounced feelings of worthlessness. She frequently expressed excessive guilt related to perceived maternal inadequacy, often stating that she was “not a good mother.” The patient also reported difficulty bonding with her newborn and described avoiding prolonged interaction with the infant due to feelings of emotional detachment and lack of confidence in caregiving.

During the fifth and sixth postpartum weeks, the severity of symptoms increased further. The patient described pervasive hopelessness and passive thoughts of death, stating that her family might be “better off without her.” However, she denied any active suicidal ideation, intent, or plan. There were no hallucinations, delusions, or other psychotic symptoms. The patient had no prior psychiatric history, substance use, or significant medical illness.

The pregnancy had been unplanned but was ultimately accepted by the patient and her family. She reported experiencing limited emotional support within the household and perceived criticism from her mother-in-law regarding infant care practices. The patient described feeling overwhelmed by caregiving responsibilities and perceived pressure to fulfill cultural expectations of ideal motherhood. Sleep deprivation and interpersonal stress within the family environment appeared to exacerbate her psychological distress.

On mental status examination, the patient appeared cooperative but visibly distressed, with mild psychomotor retardation. Her mood was depressed with a constricted affect. Thought content revealed pervasive negative cognitions centered on maternal inadequacy and self-criticism. Passive death wishes were present without suicidal intent. There was no evidence of thought disorder or perceptual disturbance. Orientation, attention, and memory were intact.

Psychometric assessment was performed to quantify depressive symptom severity. The Edinburgh Postnatal Depression Scale (EPDS) score was **18**, indicating probable postpartum depression. The Beck Depression Inventory-II (BDI-II) score fell within the **moderate depressive range**. Basic medical screening was conducted to exclude potential organic causes of depressive symptoms. Thyroid function tests and hemoglobin levels were within normal limits, and no obstetric complications were reported.

Based on the clinical presentation, psychometric findings, and fulfillment of **DSM-5-TR diagnostic criteria**, a diagnosis of **Major Depressive Disorder with Peripartum Onset** was established. The patient was subsequently initiated on a structured Cognitive Behavioral Therapy (CBT) program aimed at reducing depressive symptoms and improving maternal adjustment.

Therapeutic Intervention

Following diagnostic evaluation, the patient was enrolled in a structured **Cognitive Behavioral Therapy (CBT)** program aimed at addressing depressive symptoms and improving maternal adjustment. The intervention consisted of **12 weekly sessions**, each lasting approximately **60 minutes**, delivered in an outpatient clinical setting by a trained therapist. (Table 1)

The treatment protocol followed standard CBT principles and was organized into **three therapeutic phases**:
psychoeducation and behavioral activation, cognitive restructuring, and problem-solving with relapse prevention.

During the **initial phase**, the patient received psychoeducation regarding postpartum depression, including its prevalence, biological and psychosocial contributors, and expected treatment outcomes. The therapist emphasized that depressive symptoms during the postpartum period are relatively common and treatable, which helped reduce the patient’s feelings of self-blame and perceived inadequacy. Behavioral activation strategies were introduced through structured activity scheduling to gradually increase engagement in daily activities that promoted a sense of accomplishment and emotional reward. Sleep hygiene strategies were also discussed to address persistent sleep disturbance.

The **second phase** of therapy focused on **cognitive restructuring**. The patient was guided to identify automatic negative thoughts related to maternal competence, such as beliefs that a “good mother should never feel overwhelmed.” Thought monitoring exercises and cognitive restructuring techniques were used to evaluate the evidence for these beliefs and develop more balanced and realistic interpretations of caregiving challenges. Through repeated practice, the patient gradually learned to recognize maladaptive thinking patterns and replace them with adaptive cognitive responses.

In the **final phase**, therapy focused on **problem-solving strategies and relapse prevention**. Communication skills training was introduced to facilitate supportive interactions with her spouse and family members. Structured problem-solving techniques were used to address interpersonal stressors and caregiving challenges within the household environment. A relapse prevention plan was developed, including identification of early warning signs of depressive relapse and strategies for maintaining emotional well-being.

In addition to individual therapy sessions, **family psychoeducation** was conducted to improve the support system surrounding the patient. Family members were educated about postpartum depression and encouraged to adopt supportive communication practices while reducing critical or dismissive responses toward the patient’s emotional experiences.

Pharmacotherapy was discussed as a potential treatment option; however, it was deferred as the patient demonstrated substantial improvement with psychotherapy alone.

Outcome and Follow-Up

Clinical progress was monitored throughout therapy using both **subjective clinical assessment** and **standardized psychometric measures**. The patient demonstrated gradual improvement in mood, cognitive outlook, and functional engagement as therapy progressed.

By the **eighth therapy session**, a marked reduction in depressive symptoms was observed. The **Edinburgh Postnatal Depression Scale (EPDS)** score decreased from **18 at baseline to 9**, representing an approximate **50% reduction in symptom severity**. The patient reported noticeable improvements in emotional stability, increased engagement in daily activities, and greater confidence in caregiving. She also described improved bonding with her infant and reported spending more time interacting with the child without feelings of inadequacy or emotional detachment.

At completion of the **12-session CBT program**, further clinical improvement was evident. The EPDS score had decreased to **5**, indicating minimal depressive symptoms. The **Beck Depression Inventory-II (BDI-II)** score similarly reflected remission, falling within the **minimal symptom range**. The patient denied any suicidal ideation or passive death wishes at this stage. In addition, she reported improved sleep quality, normalization of appetite, and increased participation in household and caregiving activities.

Functional recovery was also evident in interpersonal interactions. The patient described improved communication with her spouse and reported a more supportive family environment following psychoeducation sessions conducted with family members.

A **three-month follow-up evaluation** was conducted to assess the stability of therapeutic gains. The patient continued to maintain symptom remission and reported ongoing application of CBT-based coping strategies, including cognitive restructuring and behavioral activation techniques. No relapse of depressive symptoms was observed during the follow-up period, and the patient reported sustained improvements in maternal confidence and emotional well-being.

Overall, the clinical course demonstrated **substantial and sustained improvement following structured Cognitive Behavioral Therapy**, with both psychometric measures and clinical observations supporting treatment effectiveness.

Table 1. Summary of Cognitive Behavioral Therapy Intervention

Therapy Phase	Sessions	Key Components
Therapeutic intervention	Sessions 1–4	Education about postpartum depression, normalization of maternal adjustment challenges, activity scheduling, gradual re-engagement in pleasurable activities, sleep hygiene
Cognitive Restructuring	Sessions 5–8	Identification of automatic negative thoughts, cognitive restructuring, thought records, development of balanced alternative cognitions
Problem-Solving and Relapse Prevention	Sessions 9–12	Communication skills training, structured problem-solving, strengthening social support, relapse prevention planning

Discussion

Postpartum depression is one of the most common psychiatric complications of the peripartum period and represents a significant contributor to maternal morbidity worldwide.[9] The present case illustrates the development of Major Depressive Disorder with peripartum onset in a primiparous woman and demonstrates the effectiveness of structured Cognitive Behavioral Therapy (CBT) as a non-pharmacological treatment approach.

The patient presented with several classical features of postpartum depression, including persistent low mood, fatigue, feelings of worthlessness, sleep disturbance, and impaired maternal–infant bonding. Similar symptom patterns have been consistently reported in maternal mental health literature.[10] Importantly, early symptoms in this case, such as tearfulness and sleep disturbance, were initially attributed to normal postpartum adjustment. This highlights a common clinical challenge in which early depressive symptoms may be overlooked or minimized because they overlap with expected physiological and emotional changes following childbirth. Delayed recognition may allow symptoms to progress and negatively affect maternal functioning.

Psychosocial stressors appeared to play a substantial role in the onset and persistence of depressive symptoms in this patient. The transition to motherhood often involves significant psychological and lifestyle adjustments, particularly for first-time mothers. Factors such as sleep deprivation, increased caregiving demands, and perceived pressure to meet cultural expectations of motherhood can contribute to emotional vulnerability. In the present case, the patient reported limited emotional support and perceived criticism regarding infant care within the household. Previous research has consistently identified low perceived social support and interpersonal conflict as important risk factors for postpartum depression.[11]

Cognitive factors also contributed to the patient's clinical presentation. She demonstrated maladaptive thought patterns characterized by excessive self-criticism and rigid beliefs regarding maternal competence. According to cognitive models of depression, such dysfunctional beliefs can reinforce negative emotional states and contribute to behavioral withdrawal. Addressing these cognitive distortions is therefore an important therapeutic target.

Cognitive Behavioral Therapy directly targets the maladaptive cognitive and behavioral processes underlying depressive symptoms. In this case, behavioral activation encouraged gradual re-engagement in daily activities and caregiving tasks, which contributed to improved mood and functional recovery. Cognitive restructuring techniques were subsequently used to challenge negative automatic thoughts and replace them with more balanced and realistic interpretations of caregiving challenges.

Family psychoeducation also played an important role in the therapeutic process. Increasing awareness of postpartum depression among family members helped foster a more supportive home environment and reduce critical interactions. Enhanced social support likely contributed to the patient's sustained improvement.

Although findings from a single case report cannot be generalized to broader populations, this case highlights the importance of early identification and structured psychological intervention in postpartum depression. Routine screening using validated tools such as the Edinburgh Postnatal Depression Scale may facilitate early detection. Integrating evidence-based psychological interventions such as CBT into postpartum care can significantly improve maternal mental health outcomes.

In conclusion, this case report highlights the clinical presentation and successful management of Major Depressive Disorder with peripartum onset in a primiparous woman using a structured Cognitive Behavioral Therapy program. The patient demonstrated substantial improvement in depressive symptoms, maternal functioning, and infant bonding following a 12-session CBT intervention, with sustained benefits observed at three-month follow-up. The case underscores the importance of early identification of postpartum depressive symptoms and the role of culturally informed psychosocial assessment in guiding treatment. Structured psychological interventions such as CBT can provide an effective, non-pharmacological treatment option for postpartum depression and may contribute to improved maternal mental health and overall family well-being.

Declarations

Ethics Approval: Ethical approval was not required for this case report in accordance with institutional policies, as it describes a single clinical case without experimental intervention. All procedures were conducted in accordance with the ethical standards of clinical practice and the principles of the Declaration of Helsinki.

Patient Consent: Written informed consent was obtained from the patient for publication of this case report and any accompanying clinical information. All identifying details have been removed to ensure patient confidentiality and anonymity.

Conflict of Interest: The authors declare that they have no conflicts of interest related to this study.

Funding: The authors received no financial support for the preparation, authorship, or publication of this case report.

Author Contributions: All authors contributed to the conception, clinical assessment, manuscript preparation, and final approval of the manuscript.
Data Availability: All data generated or analyzed during this study are included in this published article. No additional datasets were generated.
Artificial Intelligence (AI) Assistance Statement: The authors acknowledge the use of artificial intelligence–assisted tools for language refinement and editorial support during manuscript preparation. All scientific content, clinical interpretation, and final manuscript decisions were reviewed and approved by the authors.

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